DAVIS VISION
EYECARE REFRAMED℠
www.davisvision.com

MEDICALLY NECESSARY PRIOR AUTHORIZATION REQUEST 2018

! *Please begin using this form immediately and discard all previous versions.*

For prior authorization submit via toll-free fax: 1 (800) 584-2329

REQUIRED INFORMATION

Patient Name ______________________ Provider Name ______________________

Patient DOB ______________________ Provider Panel # ______________________

Member Name ______________________ Provider Telephone # ______________________

Member ID # ______________________

Date of Service ______________________ Provider Fax # ______________________

SERVICE (CIRCLE ALL APPLICABLE)

Medically Necessary Contact Lens Evaluation | Medically Necessary Contact Lenses | Low Vision Exam | Low Vision Aids

EYEGLASSES PRESCRIPTION

	SPHERE	CYLINDER	AXIS	ADD	PRISM	VISUAL ACUITIES
OD						20/
OS						20/

CONTACT LENS PRESCRIPTION (IF AVAILABLE)

	SPHERE	CYLINDER	AXIS	VISUAL ACUITIES
OD				20/
OS				20/

KERATOMETRY READINGS

OD ______________________

OS ______________________

MEDICALLY NECESSARY CONTACT LENS REQUIREMENTS

Medically Necessary / Visually Required Contact Lenses are only available for the diagnoses listed below - CIRCLE ALL APPLICABLE:

Keratoconus
(K Readings and/or topography)

Aphakia

Aniridia

Anisometropia
(Eyeglasses - Rx differ more than 3dp)

Irregular Astigmatism

High Ametropia
1. Eyeglass prescription is ≥-8.00 or≥ +8.00 diopters in any meridian of one or both eyes
2. AND, eyeglass best corrected visual acuity of 20/40 or worse in either eye
3. AND, visual acuity improvement of 2 lines or more with contact lenses

Professional Fee $ ______________

Material Fee $ ______________

☐ Contact Lenses ☐ Low Vision Aids

PROVIDER COMMENTS (For clinical extenuating circumstances, please attach the medical record or relevant clinical information, patient history, previous ineffective treatment, or occupational considerations)**:**

____

NEW PROVIDER REQUIREMENT

X ____

I attest the information provided is true and accurate.

FOR DAVIS VISION USE ONLY - PLEASE DO NOT WRITE IN THE FIELDS BELOW

Determination Date: __________ AUTH #: ______________________ Authorized: YES/NO Reviewed by: ______________

COMMENTS:

CONFIDENTIALITY NOTE: The information contained in the facsimile is confidential and intended for the use of the addressee shown above. if you are neither the intended recipient nor the employer agent responsible for delivering this message, you are hereby notifiied that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopy information is strictly prohibited. If you have received this telecopy in error, please notify us by telephone to arrange for its return.

A claim must be submitted for all medically necessary contact lens requests to include a copy of the prior authorization form. Authorizations for medically necessary contact lenses are not a guarantee of payment. Final eligibility will be determined when the claim is processed. All claims are subject to a maximum allowable fee.

For reimbursement purposes, please ensure that the appropriate contact lens fitting code is submitted as per the current American Medical Association CPT definition. All materials prescribed should be described by the appropriate HCPCS Level II code as per the current American Medical Association Healthcare Procedural Coding System definition. All reimbursement rates are for combined professional services and/or materials.

To submit claims via mail or fax: Vision Care Processing; Unit P.O. Box 1525; Latham, New York 12110; 1 (888) 328-4761